Approved, SCAO JIS CODE: NCA

STATE OF MICHIGAN PROBATE COURT COUNTY CIRCUIT COURT - FAMILY DIVISION	NOTIFICATION OF NONCOMPLIANCE AND REQUEST FOR MODIFIED ORDER	FILE NO.

In the matter of _____

1. I, _____ , make this notification as the
Name (type or print)

☐ agency. ☐ mental health professional who is supervising the individual's alternative/assisted outpatient treatment program.
☐ individual.

2. The individual who is the subject of this notification was ordered to undergo a program of alternative/assisted outpatient treatment or combined hospitalization and alternative/assisted outpatient treatment.
   ☐ a. The alternative treatment has not been or will not be sufficient to prevent the individual from inflicting harm or injuries to self or others.
   ☐ b. The individual is not complying with the order for alternative/assisted outpatient treatment or combined hospitalization and alternative/assisted outpatient treatment.
   ☐ c. I believe that my alternative treatment program is not appropriate.

☐ 3. There remain _____ days of hospitalization under the last order. The individual needs immediate hospitalization.

4. This conclusion is based upon
   ☐ a. my personal observation of the individual doing the following acts and saying the following things:

_____

_____

   ☐ b. conduct and statements seen or heard by others and related to me: state the conduct and statements and the name, address, and telephone number of each witness.

_____

_____

_____

☐ 5. A psychiatrist has ordered the individual to return to the hospital.

6. **I request** the court to modify its last order of ☐ alternative treatment ☐ assisted outpatient treatment ☐ combined hospitalization and alternative/assisted outpatient treatment to direct the individual to:
   ☐ a. undergo another alternative/assisted outpatient treatment program.
   ☐ b. undergo hospitalization or combined hospitalization and alternative/assisted outpatient treatment, with hospitalization not to exceed _____ days.
   ☐ c. to be transported to the hospital by a peace officer if the individual refuses to comply with the psychiatrist's order to return to the hospital.

Date	Signature
Title	Business address
Agency	City, state, zip Telephone no.

Do not write below this line - For court use only